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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]

DECISION

MPA/142343

PRELIMINARY RECITALS

Pursuant to a petition filed July 12, 2012, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Office of the Inspector General (OIG) for the Department of Health Services (DHS) in regard to Medical Assistance, a hearing was held on September 12, 2012, at Kenosha, Wisconsin.

The issue for determination is whether Petitioner's provider has submitted evidence sufficient to demonstrate that a prior authorization request for an occupational therapy (OT) evaluation and various therapies meets the criteria necessary for payment by the Wisconsin Medical Assistance Program.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: Mary Chucka, OTR
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:

David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Kenosha County.

2. A prior authorization request (PA) seeking Medicaid payment for 52 sessions of occupational therapy (OT) at a frequency of twice a week was filed on behalf of Petitioner by his provider Tender Touch Therapy, on or about April 25, 2012. The therapy was to start May 4, 2012 and was noted on the PA to cost \$6475.00.
3. Petitioner is covered by private insurance and does cover 75 sessions of therapy per year.
4. Petitioner is 6 years of age (DOB 04/30/06). He is in all day kindergarten as of the fall of 2012. His diagnosis includes autism, and muscle weakness. He has developmental coordination issues, especially in hand dexterity and strength. He lives with his parents and has a twin brother. His parents do participate in his therapy and carry over the exercises to their home.
5. The Department denied this PA contending that the evidence does not show that requested OT has been demonstrated to be necessary to prevent or treat Petitioner's disabilities, that the requested services are not demonstrated to be an appropriate and effective level of service, that Petitioner has had well beyond the six-month limit of services without identification of exactly how it has improved Petitioner's functionality and because the appeal letter submitted on behalf of Petitioner indicated that his therapists work on Petitioner's sensory integration needs and the Department does not permit Medicaid payment for sensory integration therapy for autism.
6. The requested OT services have been provided at a frequency of twice a week during the summer of 2012. Petitioner is to receive OT in school this fall but it had not started as of the time of the hearing.

DISCUSSION

The Division of Health Care Access and Accountability may only reimburse providers for medically necessary and appropriate health care services and equipment listed in Wis. Stat. §§ 49.46(2) and 49.47(6)(a), as implemented by Wis. Admin. Code, Ch. DHS 107. Some services and equipment require submission and approval of a written prior authorization request by the provider. Some services and equipment are never covered. Occupational therapy is a service that requires approval of a request for prior authorization. *See, generally, Wis. Admin. Code, § DHS 107.17.* A PA is required after 35 lifetime OT sessions. *Wis. Admin. Code, § DHS, 107.17(2)(a).*

When determining whether to approve any prior authorization, the Division of Health Care Access and Accountability (DHCAA) must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, § DHS 107.02(3)(e)*. Those criteria are:

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
7. The effective and appropriate use of available services;
8. The misutilization practices of providers and recipients;

9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

The Wisconsin Administrative Code does define the term ‘medical necessity’. It is a service that:

“Medically necessary” means a medical assistance service under ch. DHS 107 that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
 3. Is appropriate with regard to generally accepted standards of medical practice;
 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
 6. Is not duplicative with respect to other services being provided to the recipient;
 7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Wis. Admin. Code, § DHS 101.03(96m).

As with most public assistance benefits the initial burden of demonstrating eligibility for any particular benefit or program at the operational stage falls on the applicant, *Gonwa v. Department of Health and Family Services*, 2003 WI App 152, 265 Wis.2d 913, 668 N.W.2d 122 (Ct.App.2003). In other words, it is a petitioner’s burden to demonstrate that s/he qualified for the requested continued services by a preponderance of the evidence. It is not the Department’s burden to prove that s/he is not eligible. Further, I note that Medicaid is meant to provide the most basic and necessary health care services at a reasonable cost to a large number of persons and must authorize services according to the Wisconsin Administrative Code definition of medical necessity and other review criteria noted above. It is not enough to demonstrate a benefit; rather, all of the tests cited above must be met.

The Department maintains that the treating therapist has not quantitatively identified what Petitioner can and cannot do so as objectively evaluate his capabilities and the change in baseline status. The Department notes that goals have been in place since 2009 without an objective demonstration that therapy has contributed to any advancement Petitioner has made, as opposed to the changes in his abilities being attributable to his own development as well as carry over practice in the home. As an example, the Department notes that between May 2009 and September 2011 the provider indicated that OT services would continue to address "strengthening of bilateral upper extremities; bilateral coordination, hand dexterity, trunk control and strengthening, fine motor skills, prehension patterns, self-care skills and provide family with home exercise program." It does not describe how OT is to address these problems and simply notes that Petitioner’s progressing without a quantitative basis for that conclusion. The department notes that while it appears that some goals have changed, it is really just semantics. As an example, it notes that in May 2009 Petitioner had a goal to put his shirt on with only set up and minimal

cues 2 of 3 times and in in October of 2011 has the goal stated as Petitioner is to don and doff his shirt with only set up for orientation 2 of 3 times. *See Exhibit # 3, July 25, 2012 letter from the Office of the Inspector General of the Department of Health Services, by Mary Chucka, OTR.*

Petitioner's mother testified that Petitioner has shown considerable progress in the private therapy in the areas dressing and feeding himself. She indicated that this has been important with his attendance in school this fall because he is able to take his coat on and off and because he needs less help using the bathroom. She also notes that the in-home autism therapy that Petitioner receives is care provided by mostly college-age students with no training occupational therapy and whose directions are to primarily address behavioral issues. She knows that he is behind his peers in terms of physical abilities; and despite progress in some areas still has deficits as to bathing, tying shoes and cutting food.

In reviewing the prior authorization request and the materials submitted with it as documentation, I agree with the Department that services and results goals are somewhat repetitive and subjective and there is a lack of classification of methodology and quantification of results. The strongest argument for continuing to provide services is the testimony of Petitioner's mother but that testimony does not provide the objective information it is the responsibility of the provider to submit.

Ultimately, I am sustaining the department denial in this case. My reasons for doing so really boils down to the fact that Petitioner has had occupational therapy for in excess of six month limit without a demonstration by the provider that the requested OT meets the test of Wis. Admin. Code DHS 107.17 (3) which would allow the extension of OT services beyond six months. Additionally, sensory integration therapy is not covered by Medicaid and there is a suggestion that that is part of the service provided by the occupational therapists. Finally, it is not enough to show that occupational therapy is of benefit; it is also necessary to document exactly why skilled intervention is medically necessary.

NOTE: Petitioner's provider will not receive a copy of this Decision form the Division of Hearings and Appeals but Petitioner's parents are free to share it if they so desire.

CONCLUSIONS OF LAW

That Petitioner's provider has not submitted evidence sufficient to demonstrate that a prior authorization request for an occupational therapy (OT) meets the criteria necessary for payment by the Wisconsin Medicaid Program.

THEREFORE, it is

ORDERED

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as

"PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

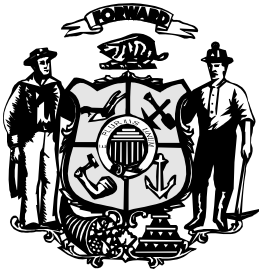
For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 10th day of October, 2012

David D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

c: Division of Health Care Access And Accountability - email
Department of Health Services - email



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The preceding decision was sent to the following parties on October 10, 2012.

Division of Health Care Access And Accountability